Reset Form

Civilian Employee Physical Fitness (CEPF) Program Certification Sheet

Name of Participant (Last, First, MI):

I understand the PSA Jacksonville CEPF Program is strictly voluntary and that participation is a personal choice of each employee.

I acknowledge that this program utilizes official working hours to enable participation in an exercise program. As such, the rules of conduct concerning work time apply. My programs will consist of:

Activity: _____
Location of Activity: _____
Times per week: _____

I understand that consulting with my physician before beginning any excerise program is a wise decision; however, it is my decision to make.

☐ I consulted with my physician and evidence of my physician's approval of my selected fitness activity(ies) has been given to my immediate supervisor and detachment physical fitness coordinator and it will not be used for any other purpose.

☐ I choose not to consult with my physician. I have completed the screening below indicating that there is no medical reason known to me that would prohibit my participation in this program.

YES	NO	QUESTION
		Are you now 45 years old or older and not accustomed to the level of exercise you wish to pursue?
		Since your last physical, has there been a significant change in your history of heart disease/high blood pressure that required you to seek medical treatment or restrict physical activity?
		Since your last physical, has there been a significant change in discomfort in your chest, arms, or neck while exerting yourself?
		Since your last physical, has there been an incident where you have fainted or felt you were about to lose consciousness?
		Do you have a condition (diabetes, asthma, etc.) that you think might limit your participation in an exercise program?
		Has there been an incidence in your family where your mother, father, brother or sister had a heart attack or died of heart disease before they were 45 years old?
		Has there been a significant change in your weight?
		Do you use tobacco products?

Signature of Participant:	Date:
Signature of Supervisor:	Date:
Signature of CEPF Coordinator:	Date:

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